DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 98-18

2. STATE: OKLAHOMA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07-01-98

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.200

7. FEDERAL BUDGET IMPACT:
a. FFY 98 $ 461,579
b. FFY 99 $1,391,217

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 3
Attachment 4.19-A, Page 3.1
Attachment 4.19-A, Page 5
Attachment 4.19-A, Page 5.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same Page, Revised 5-1-94, TN#94-09
Same Page, Revised 2-1-93, TN#93-05
Same Page, Revised 2-1-93, TN#93-05
Same Page, Revisd 2-1-93, TN#93-05

10. SUBJECT OF AMENDMENT:
Changes in reimbursement methodology for in-patient hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
for

13. TYPED NAME:
Garth L. Splinter, M.D.

14. TITLE:
C.E.O., OHCA

15. DATE SUBMITTED: 9/30/98

16. RETURN TO:
Oklahoma Health Care Authority
Attn: Billie Wright
4545 N. Lincoln, Suite 124
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 30, 1998

18. DATE APPROVED: October 27, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 1998

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Calvin G. Cline

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

RECEIVED
SEP 30 1998
HCFA
DIVISION OF MEDICAID
RO VI - DALLAS

23. REMARKS:

c: Mike Fogarty
Jim Hancock
Billie Wright
Leigh Brown

FORM HCFA-179 (07-92)

Instructions on Back

METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

Direct Medical Education Per Diem – The third rate component, a hospital-specific direct medical education per diem, is paid to those hospitals with allowable direct medical education costs as defined in HCFA publication 15-1 for Medicare cost reporting purposes and reported on the HCFA 2552. New hospitals must have 12 full months of cost report data in order to receive a hospital-specific direct medical education per diem. For purposes of this amendment, effective July 1, 1998, direct medical education per diem rates will be updated by multiplying the prior year medical education per diem rate by the update factor described on Page 3.

A cost variance adjustment factor (CVAF) as described on page 4, or a fraction thereof, will be applied prospectively to the inflated direct medical education per diems prior to the start of the State fiscal year when:

1. the reimbursement system changes from statewide or peer group medians to facility-specific per diems and the variance is greater than 1.5% at the 50th percentile; or,

2. at least 25% of the in-state facilities have filed a rate appeal in the immediately preceding fiscal year and the variance is greater than 1.5% at the 50th percentile.

B. **Out-of-State Hospitals**

Hospitals, for which the department has on file a fiscal year 1989 or more recent full year cost report, are reimbursed the same as in-state Oklahoma hospitals.

Hospitals, for which the Department does not have a fiscal year 1989 or more recent cost report on file, will also receive the level of care per diem rates. However, capital and direct medical education rate components will not be reimbursed on a hospital-specific basis. Instead, these hospitals shall receive the statewide median capital per diem amount. The statewide median direct medical education per diem rate will be paid to qualifying hospitals.

In the absence of substantiating information verifying eligibility for the teaching hospital peer group, an out-of-state hospital will be presumed to be a non-teaching hospital and will be paid at the non-teaching rate for levels 7 and 8. A retroactive adjustment will be made for the difference in the teaching/non-teaching rates if eligibility is subsequently determined for services provided on or after the effective date of eligibility.

Superseded by OIL 00-14

STATE Oklahoma
DATE REC'D 09-30-98
DATE APPV'D 10-27-00
DATE EFF 07-01-98
HCFA 179 98-18

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TN # 98-18 Approval Date 10/27/00 Effective Date 07/01/98

Supersedes
TN # 93-05

METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

Step 2. The sum of each level of care offered within a category will be divided by the number of patient levels of care offered within a category to arrive at an average per diem for each category.

Step 3. A value factor each patient level of care within a category will be determined by dividing the operating (level of care) prospective rate for each level of care b the average operating (level of care) prospective rate for each category.

Step 4. The value factor (from Step 3) will be multiplied by the statewide median capital per diem to arrive at the weighted fixed capital per diem reimbursement-rate.

3. Adjustments. The statewide median per diem capital amount is calculated from 1989 uniform cost report data from each fiscal year ending in calendar 1989. Costs were inflated to a common point in time prior to the calculation of the median cost per day. The statewide fixed capital per diem average of all free-standing psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals are annually inflated effective July 1 of each year by the latest one year District Comparative Cost Multiplier for the Central Region, Class A Construction, in the January edition of the Marshall Valuation Services, published by Marshall & Swift. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year using later available forecasts or actual inflationary changes. Effective July 1, 1998, no annual adjustment will be applied to the statewide fixed capital per diem average of all free-standing psychiatric hospitals and the statewide fixed capital per diem median of all inpatient hospitals.

New in-state hospital providers (this does not include hospitals having a change of ownership) lacking 12 months of cost report information shall receive the statewide capital per diem amount. After submittal of the first full year's cost report, capital payments will be in accordance with the methodology described above.

OK 00-14

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DATE APPVD 10-27-00
DATE EFF 07-01-98
HCFA 179 98-18
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Supersedes TN # 93-15

SUPERSEDED BY 98-18

METHODS AND STANDARDS OF REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

For services on or after February 1, 1993 through June 30, 1993, hospitals with allowable costs above the statewide median level of care will be limited to reimbursement of the statewide median level of care rate, except for levels 7 and 8, which will not exceed the peer group median. When a hospital's allowable costs are less than the statewide median level of care, 62.5 percent of the difference will be added to the hospital's specific facility level of care rate. Beginning July 1, 1993, the add-on to the facility specific level of care rate will be 25 percent of the difference between the statewide median level of care rate (except levels 7 and 8) and the hospital's specific level of care rate.

Hospital-specific costs per day within each level of care were calculated using the following steps:

a. Claims were categorized into levels of care.
b. Using uniform cost report information for the corresponding time period, charges submitted on the claims were converted to costs using facility-specific cost-to-charge ratios (fixed capital and direct medical education costs were removed at this time.)
c. All costs were inflated to a uniform point in time (the midpoint of the state's payment year.)
d. Peer grouping analyses were performed to evaluate statistically significant differences in costs across categories of hospitals (e.g., teaching versus nonteaching).
e. Facility-specific costs per day were calculated for each level of care category.

These hospital-specific rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the facility specific costs per day.

Facility-specific per diem rates are inflated annually effective July 1 of each year using the first quarter publication of the Data Resources, Inc. (DRI) PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year, prior to the start of the state fiscal year.

STATE	Oklahoma	A
DATE RECD	01-06-93	
DATE APPD	02-06-97	
DATE EFF	02-01-93	
HCFA 179	93-05	

New 02-01-93

METHODS AND STANDARDS OF REIMBURSEMENT
FOR INPATIENT HOSPITAL SERVICES

The only two exceptions to this logic are for payment for claims in Level 7 and for payment for routine inpatient surgical procedures. Payment for claims classified into Level 7 will be made at two level of care rates when a claim has both ICU/CCU revenue code charges and routine revenue code charges. When this occurs, payment is split between Levels 7 and 8. Claims for a single stay shall not be split and submitted as two claims solely for the purpose of obtaining two different level of care payment rates (except when patients receiving psychiatric care in acute care hospitals are transferred to medical units because their non-psychiatric medical needs become the primary cause of hospitalization). There are two restrictions on these levels of care:

1. Only Level III neonatal units will be paid the NICU level of care per diem rate. For rate setting purposes a hospital is considered eligible to receive the Level III NICU rate if it meets the criteria used by the Health Planning Commission (now part of the Oklahoma Department of Health) in its 1988 Hospital Utilization and Plan Survey.

2. All claims from free-standing inpatient psychiatric hospitals will be paid at the Level 6, Psychiatric, level of care rate. (Psychiatric claims from acute care hospitals will also be paid at the Level 6 rate).

Payment rates for Level 7 (ICU/CCU) and Level 8 (Routine) are peer grouped based on hospital teaching and nonteaching status. For payment purposes, hospitals that either (1) belong to the Council on Teaching Hospitals, or (2) have a medical school affiliation qualify for the teaching peer grouped rate for Levels 7 and 8. All other hospitals receive the nonteaching rate for Levels 7 and 8.

The second exception provides for payment of specified routine inpatient surgical procedures at the routine care per diem rate instead of the surgical care per diem rate. This exception is effective for services provided on or after May 1, 1994.

These level of care rates are calculated from 1988 claims and uniform cost report data from each provider's fiscal year ending in calendar 1988. Costs were inflated to a common point of time prior to calculation of the median cost per day.

Level of care per diem rates are inflated annually effective July 1 of each year using the lesser of the available Data Resources, Inc. (DRI) PPS-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year or the latest Health Care Financing Administration (HCFA) proposed update factor for non-PPS (exempt) hospitals published in the Federal Register or in federal legislation, whichever is later, prior to the start of the state fiscal year. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year solely as a result of later available forecasts or actual inflationary changes.

Effective July 1, 1998, rates will no longer be updated annually according to the DRI methodology above. Effective July 1, 1998 rates will be updated using the prior year level of care per diem multiplied by an update factor. The update factor will be determined by multiplying the DRI fourth quarter index's forecast for the midpoint of the state fiscal year (2.4% for SFY99) by the HCFA PPS-type Hospital Marketbasket weight assigned for compensation (61.39% for SFY99). A state plan amendment will be submitted to update future rate periods.

Superseded By OK 00-14

TN # 98-18 Approval Date 12/21/00 Effective Date 07/01/98

Supersedes TN # 94-09

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